		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0029892

Facility Name: APOSTOLIC CHRISTIAN RESTHAVEN

Address: 2750 WEST HIGHLAND AVENUE (Number) ELGIN (City) 60123 (Zip Code)

County: KANE

Telephone Number: 847-741-4543 **Fax #** 847-741-4562

IDPA ID Number: 36-2732524001

Date of Initial License for Current Owners: 11/07/85

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	X	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501(c)(3)			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: Dave Stieglitz, Administrator **Telephone Number:** 847-741-4543

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from Jan. 1, 2000 to Dec. 31, 2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) David Stieglitz
(Title) Administrator

Paid Preparer

(Signed) An accountants' compilation report is attached. (Date)
(Print Name and Title) Lawrence F. Lenard, Partner
(Firm Name & Address) Borhart, Spellmeyer & Company
2295 Valley Creek Drive, Elgin, IL 60123
(Telephone) 847-695-1775 Fax # 847-695-1984

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number APOSTOLIC CHRISTIAN RESTHAVEN # 0029892 Report Period Beginning: Jan. 1, 2000 Ending: Dec. 31, 2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds n/a

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	50	Skilled (SNF)	50	18,300	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	50	TOTALS	50	18,300	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,047	4,726		7,773	8
9	SNF/PED					9
10	ICF	2,004	7,333		9,337	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,051	12,059		17,110	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.50%

D. How many bed-hold days during this year were paid by Public Aid?
5 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
meals, hair care, personal care for apartment residents

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [x] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 11/07/85

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [x] If YES, enter number of beds certified and days of care provided

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: December 31 Fiscal Year: December 31

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number APOSTOLIC CHRISTIAN RESTHAVEN # 0029892 Report Period Beginning: Jan. 1, 2000 Ending: Dec. 31, 2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	203,436	9,660	600	213,696		213,696		213,696			1
2	Food Purchase		89,132		89,132		89,132	(18,786)	70,346			2
3	Housekeeping	55,510	9,432		64,942		64,942		64,942			3
4	Laundry	29,433	3,679		33,112		33,112		33,112			4
5	Heat and Other Utilities			50,820	50,820		50,820		50,820			5
6	Maintenance	38,519		26,947	65,466		65,466		65,466			6
7	Other (specify):*											7
8	**TOTAL General Services**	326,898	111,903	78,367	517,168		517,168	(18,786)	498,382			8
	B. Health Care and Programs											
9	Medical Director			2,000	2,000		2,000		2,000			9
10	Nursing and Medical Records	951,266	9,138	72,240	1,032,644		1,032,644	540	1,033,184			10
10a	Therapy			2,970	2,970		2,970		2,970			10a
11	Activities	42,216	5,022	2,138	49,376		49,376	475	49,851			11
12	Social Services	30,762	1,376	2,699	34,837		34,837		34,837			12
13	Nurse Aide Training			2,966	2,966	(2,966)						13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,024,244	15,536	85,013	1,124,793	(2,966)	1,121,827	1,015	1,122,842			16
	C. General Administration											
17	Administrative	61,828			61,828		61,828		61,828			17
18	Directors Fees											18
19	Professional Services			17,816	17,816		17,816		17,816			19
20	Dues, Fees, Subscriptions & Promotions			8,141	8,141		8,141	(1,208)	6,933			20
21	Clerical & General Office Expenses	37,349	4,452	6,253	48,054		48,054		48,054			21
22	Employee Benefits & Payroll Taxes			253,327	253,327	14,491	267,818	1,264	269,082			22
23	Inservice Training & Education			5,432	5,432	907	6,339		6,339			23
24	Travel and Seminar			336	336	2,059	2,395	(2,160)	235			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			13,327	13,327		13,327		13,327			26
27	Other (specify):*			15,732	15,732	(14,491)	1,241	(960)	281			27
28	**TOTAL General Administration**	99,177	4,452	320,364	423,993	2,966	426,959	(3,064)	423,895			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,450,319	131,891	483,744	2,065,954		2,065,954	(20,835)	2,045,119			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number APOSTOLIC CHRISTIAN RESTHAVEN #0029892 Report Period Beginning: Jan. 1, 2000 Ending: Dec. 31, 2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			126,136	126,136		126,136	(30,079)	96,057			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							(20,019)	(20,019)			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			126,136	126,136		126,136	(50,098)	76,038			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		54,815	76,130	130,945		130,945		130,945			39
40	Barber and Beauty Shops	25,815	208	353	26,376		26,376		26,376			40
41	Coffee and Gift Shops		1,334		1,334		1,334	(1,334)				41
42	Provider Participation Fee			27,450	27,450		27,450		27,450			42
43	Other (specify):*		1,591	42,174	43,765		43,765	(42,169)	1,596			43
44	**TOTAL Special Cost Centers**	25,815	57,948	146,107	229,870		229,870	(43,503)	186,367			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,476,134	189,839	755,987	2,421,960		2,421,960	(114,436)	2,307,524			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number APOSTOLIC CHRISTIAN RESTHAVEN # 0029892 Report Period Beginning: Jan. 1, 2000 Ending: Dec. 31, 2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(18,786)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(1,006)	30		9
10	Interest and Other Investment Income	(20,019)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(79)	27		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(29,073)	30		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(175)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,033)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(46,544)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (116,715)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule	2,279		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 2,279		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (114,436)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

APOSTOLIC CHRISTIAN RESTHAVEN

ID# 0029892

Report Period Beginning: Jan. 1, 2000

Ending: Dec. 31, 2000

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Out-of-state travel	$ (2,059)	24	1
2	Apartment expense	(42,169)	43	2
3	Vending	(1,334)	41	3
4	Volunteer expense	(881)	27	4
5	Non-care vehicle expense	(101)	24	5
6	Donated goods-plants/paintings/subscriptions	475	11	6
7	Donated goods-wheelchair	100	10	7
8	Donated goods-chair, medical supplies	230	10	8
9	Donated goods-rolling walker	25	10	9
10	Donated goods-medical equipment	150	10	10
11	Donated goods-rolling walker	25	10	11
12	Donated goods-stationary walker	10	10	12
13	Donated goods-staff appreciation gift certificates, tickets	1,264	22	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
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78				78
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80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	(44,265)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number APOSTOLIC CHRISTIAN RESTHAVEN # 0029892 Report Period Beginning: Jan. 1, 2000 Ending: Dec. 31, 2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(18,786)	0	0	0	0	0	0	0	0	0	0	(18,786)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(18,786)	0	0	0	0	0	0	0	0	0	0	(18,786)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	540	0	0	0	0	0	0	0	0	0	0	540	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	475	0	0	0	0	0	0	0	0	0	0	475	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	1,015	0	0	0	0	0	0	0	0	0	0	1,015	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(1,208)	0	0	0	0	0	0	0	0	0	0	(1,208)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	1,264	0	0	0	0	0	0	0	0	0	0	1,264	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(2,160)	0	0	0	0	0	0	0	0	0	0	(2,160)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(960)	0	0	0	0	0	0	0	0	0	0	(960)	27
28	**TOTAL General Administration**	(3,064)	0	0	0	0	0	0	0	0	0	0	(3,064)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(20,835)	0	0	0	0	0	0	0	0	0	0	(20,835)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **APOSTOLIC CHRISTIAN RESTHAVEN** **#** **0029892** **Report Period Beginning:** **Jan. 1, 2000** **Ending:** **Dec. 31, 2000**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(30,079)	0	0	0	0	0	0	0	0	0	0	(30,079)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(20,019)	0	0	0	0	0	0	0	0	0	0	(20,019)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(50,098)	0	0	0	0	0	0	0	0	0	0	(50,098)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	(1,334)	0	0	0	0	0	0	0	0	0	0	(1,334)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(42,169)	0	0	0	0	0	0	0	0	0	0	(42,169)	43
44	**TOTAL Special Cost Centers**	(43,503)	0	0	0	0	0	0	0	0	0	0	(43,503)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(114,436)	0	0	0	0	0	0	0	0	0	0	(114,436)	45

Facility Name & ID Number APOSTOLIC CHRISTIAN RESTHAVEN # 0029892 Report Period Beginning: Jan. 1, 2000 Ending: Dec. 31, 2000

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	27	Rent-land	$ 1	Apostolic Christian Church of Elgin	100.00%	$ 1	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1			$ 1	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number APOSTOLIC CHRISTIAN RESTHAVEN # 0029892 Report Period Beginning: Jan. 1, 2000 Ending: Dec. 31, 2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number APOSTOLIC CHRISTIAN RESTHAVEN # 0029892 Report Period Beginning: Jan. 1, 2000 Ending: c. 31, 2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [x]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number APOSTOLIC CHRISTIAN RESTHAVEN # 0029892 Report Period Beginning: Jan. 1, 2000 Ending: Dec. 31, 2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number APOSTOLIC CHRISTIAN RESTHAVEN # 0029892 Report Period Beginning: Jan. 1, 2000 Ending: Dec. 31, 2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1995		8
1996		9
1997		10
1998		11
1999		12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number APOSTOLIC CHRISTIAN RESTHAVEN # 0029892 Report Period Beginning: Jan. 1, 2000 Ending: Dec. 31, 2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 22,600 care related B. General Construction Type: Exterior 80% brick/20% cedar Frame steel Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Eigteen (18) congregate housing units (apartments) are attached to the nursing home. Utilities are separately metered and costs are handled separately.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number APOSTOLIC CHRISTIAN RESTHAVEN # 0029892 Report Period Beginning: Jan. 1, 2000 Ending: Dec. 31, 2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	49		1985	1985	$ 2,033,874	$ 50,847	40	$ 50,847	$	$ 779,272	4
5			1986	1986	10,064	252	40	252		3,652	5
6			1987	1987	67,246	1,681	40	1,681		22,693	6
7	1		1988	1988	91,817	2,295	40	2,295		28,688	7
8			1999	1999	74,929	1,873	40	1,873		2,653	8
	Improvement Type**										
9	Land improvements			1985	24,667	1,514	15	1,514		24,538	9
10	Land improvements			1986	4,800	320	15	320		4,560	10
11	Land improvements			1989	2,069	138	15	138		1,598	11
12	Land improvements			1990	590	39	15	39		403	12
13	Land improvements			1992	3,525	235	15	235		1,998	13
14	Land improvements			1992	26,596	1,773	15	1,773		14,627	14
15	Land improvements-front court			1997	15,126	1,008	15	1,008		3,444	15
16	Land improvements-blacktop			1997	16,291	1,086	15	1,086		3,620	16
17	Building improvements			1986	1,400	70	20	70		986	17
18	Building improvements			1987	8,669	433	20	433		5,729	18
19	Building improvements			1988	28,461	1,423	20	1,423		17,787	19
20	Building improvements			1989	500	25	20	25		292	20
21	Building improvements			1990	6,091	305	20	305		3,185	21
22	Building improvements			1991	6,846	342	20	342		3,152	22
23	Building improvements			1992	13,749	687	20	687		5,840	23
24	Building improvements			1992	1,331	67	20	67		569	24
25	Building improvements			1994	885	44	20	44		282	25
26	Building improvements			1995	18,663	1,864	10	1,864		10,386	26
27	Building improvements			1996	6,987	698	10	698		3,254	27
28	Building improvements			1996	809	40	20	40		187	28
29	Building improvements-code alert			1997	1,164	116	10	116		416	29
30	Building improvements-patio door			1998	2,100	105	20	105		289	30
31	Building improvements-automatic door opener			1998	2,029	101	20	101		261	31
32	Building improvements-music room carpet			1998	2,671	267	10	267		645	32
33	Building improvements-kitchen air conditioning			1999	4,500	225	20	225		413	33
34	Building improvements-kitchen air conditioning			1999	3,882	194	20	194		340	34
35	Building improvements-cabinets			1999	389	19	20	19		33	35
36	TOTAL (lines 4 thru 35)				$ 2,482,720	$ 70,086		$ 70,086	$	$ 945,792	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number APOSTOLIC CHRISTIAN RESTHAVEN # 0029892 Report Period Beginning: Jan. 1, 2000 Ending: Dec. 31, 2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building improvements-cabinets			1999	310	16	20	16		28	9
10	Building improvements-carpeting 2 offices			1999	1325	66	20	66		116	10
11	Building improvements-kitchen air conditioning wiring			1999	985	49	20	49		82	11
12	Building improvements-dining room blinds			1999	656	33	20	33		39	12
13	Building improvements-garbage disposal			2000	1,975	58	20	58		58	13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 5,251	$ 222		$ 222	$	$ 323	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number APOSTOLIC CHRISTIAN RESTHAVEN # 0029892 Report Period Beginning: Jan. 1, 2000 Ending: Dec. 31, 2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 180,417	$ 20,504	$ 20,504	$	five/ten	$ 263,511	37
38	Current Year Purchases	25,102	2,898	2,898		five/ten	2,898	38
39	Fully Depreciated Assets	171,940						39
40								40
41	TOTALS	$ 377,459	$ 23,402	$ 23,402	$		$ 266,409	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Van	1996 National Mobility	1996	$ 33,525	$ 3,353	$ 2,347	$ (1,006)	10	$ 16,206	42
43										43
44										44
45										45
46	TOTALS			$ 33,525	$ 3,353	$ 2,347	$ (1,006)		$ 16,206	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 2,898,955	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 97,063	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 96,057	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (1,006)	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,228,730	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	Apartments-1986/1990/1999	$ 924,274	$ 23,107	$ 275,801	52
53	Land improvements-1986/1990/1991/1997	94,036	4,814	55,161	53
54	Equipment-1986-1999	42,662	873	41,462	54
55	Building improvements-1999	5,100	254	410	55
56	Building improvements-2000	1,361	25	25	56
57	TOTALS	$ 1,067,433	$ 29,073	$ 372,859	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number APOSTOLIC CHRISTIAN RESTHAVEN # 0029892 Report Period Beginning: Jan. 1, 2000 Ending: Dec. 31, 2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [x] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number APOSTOLIC CHRISTIAN RESTHAVEN # 0029892 Report Period Beginning: Jan. 1, 2000 Ending: Dec. 31, 2000

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care	39-2	visits				2,143		2,143	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2/39-3	# of prescrpts		1,264	76,130	426	1,264	76,556	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): personal supplies	39-2					52,246		52,246	13
14	TOTAL			$	1,264	$ 76,130	$ 54,815	1,264	$ 130,945	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number APOSTOLIC CHRISTIAN RESTHAVEN # 0029892 Report Period Beginning: Jan. 1, 2000 Ending: Dec. 31, 2000

XV. BALANCE SHEET - Unrestricted Operating Fund. As of Dec. 31, 2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 72,265	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	160,668		3
4	Supply Inventory (priced at cost)	18,124		4
5	Short-Term Investments			5
6	Prepaid Insurance	35,938		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Accrued Interest	3,999		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 290,994	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	3,512,742		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	453,646		16
17	Accumulated Depreciation (book methods)	(1,601,589)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	259,390		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,624,189	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,915,183	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 25,245	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	87,502		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Deferred Income-Advance Billings	127,764		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 240,511	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Deposits-Apartments	359,700		43
44	Deferred Income-Apartments	1,673		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 361,373	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 601,884	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,313,299	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,915,183	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number APOSTOLIC CHRISTIAN RESTHAVEN # 0029892 Report Period Beginning: Jan. 1, 2000 Ending: Dec. 31, 2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,287,916	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,287,916	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	25,383	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 25,383	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,313,299	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number APOSTOLIC CHRISTIAN RESTHAVEN # 0029892 Report Period Beginning: Jan. 1, 2000 Ending: Dec. 31, 2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,045,537	1
2	Discounts and Allowances for all Levels	(25,854)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,019,683	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	900	6
7	Oxygen	878	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,778	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	3,025	13
14	Non-Patient Meals	8,910	14
15	Telephone, Television and Radio	306	15
16	Rental of Facility Space		16
17	Sale of Drugs	83,082	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	20	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 95,343	23
	D. Non-Operating Revenue		
24	Contributions	185,711	24
25	Interest and Other Investment Income***	20,019	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 205,730	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Schedule	124,809	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 124,809	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,447,343	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	517,168	31
32	Health Care	1,124,793	32
33	General Administration	423,993	33
	B. Capital Expense		
34	Ownership	126,136	34
	C. Ancillary Expense		
35	Special Cost Centers	202,420	35
36	Provider Participation Fee	27,450	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,421,960	40
41	**Income before Income Taxes (line 30 minus line 40)****	25,383	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 25,383	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** yes **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number APOSTOLIC CHRISTIAN RESTHAVEN # 0029892 Report Period Beginning: Jan. 1, 2000 Ending: Dec. 31, 2000

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,960	2,146	$ 48,581	$ 22.64	1
2	Assistant Director of Nursing	2,224	2,327	40,456	17.39	2
3	Registered Nurses	12,065	12,924	260,331	20.14	3
4	Licensed Practical Nurses	4,998	5,492	97,480	17.75	4
5	Nurse Aides & Orderlies	36,316	39,543	466,003	11.78	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,039	2,234	27,431	12.28	8
9	Activity Director	1,950	2,099	21,773	10.37	9
10	Activity Assistants	2,113	2,257	20,443	9.06	10
11	Social Service Workers	2,216	2,362	30,762	13.02	11
12	Dietician	1,903	2,096	38,355	18.30	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,838	17,254	165,081	9.57	15
16	Dishwashers					16
17	Maintenance Workers	2,108	2,315	38,519	16.64	17
18	Housekeepers	6,117	6,794	55,510	8.17	18
19	Laundry	2,859	3,159	29,433	9.32	19
20	Administrator	1,971	2,105	61,828	29.37	20
21	Assistant Administrator					21
22	Other Administrative	1,241	1,326	10,984	8.28	22
23	Office Manager					23
24	Clerical	3,202	3,313	37,349	11.27	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Barber/Beauty	1,875	2,082	25,815	12.40	33
34	TOTAL (lines 1 - 33)	102,995	111,828	$ 1,476,134 *	$ 13.20	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	12	$ 600	1-3	35
36	Medical Director	4	2,000	9-3	36
37	Medical Records Consultant	16	854	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	84	3,900	10-3	39
40	Physical Therapy Consultant	51	2,970	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	48	2,138	11-3	44
45	Social Service Consultant	46	2,699	12-3	45
46	Other(specify) Beatician/Haircare	18	228	40-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	279	$ 15,389		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	3,665	67,486	10-3	52
53	TOTAL (lines 50 - 52)	3,665	$ 67,486		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number APOSTOLIC CHRISTIAN RESTHAVEN # 0029892 Report Period Beginning: Jan. 1, 2000 Ending: Dec. 31, 2000

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
David Stieglitz	Administrator	0.0	$ 61,828
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 61,828

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Borhart, Spellmeyer & Company	CPA	$ 11,430
Paychex, Inc.	Payroll services	4,067
Wagner Office Solutions	Office equipment maintenance	1,104
Microage Computer Services	Computer network support	1,000
Gardner & White	Form 5500 employee plans	215
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 17,816

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 12,372
Unemployment Compensation Insurance	0
FICA Taxes	110,644
Employee Health Insurance	86,405
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Life insurance	1,877
Pension expense	40,158
Employee health services	1,871
Employee relations-see attached schedule	14,491
Employee relations-donated goods adjustment	1,264
TOTAL (agree to Schedule V, line 22, col.8)	$ 269,082

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 0
Advertising: Employee Recruitment	3,485
Health Care Worker Background Check	228
(Indicate # of checks performed 19)	
City restaurant license	140
Association dues	2,828
Chamber of commerce	175
Publications	247
Corporation fees	5
Newsletter	1,033
Less: Public Relations Expense	(175)
Non-allowable advertising	(1,033)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,933

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 2,059
In-State Travel	
Vehicle expense	336
Seminar Expense	
Less out-of-state travel adjustment	(2,059)
Less non-care vehicle expense adjustment	(101)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 235

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number APOSTOLIC CHRISTIAN RESTHAVEN # 0029892 Report Period Beginning: Jan. 1, 2000 Ending: Dec. 31, 2000

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **no**

(2) Are there any dues to nursing home associations included on the cost report? **yes**
If YES, give association name and amount. **Life Services Network 1,978; AAHSA 675**

(3) Did the nursing home make political contributions or payments to a political action organization? **no** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **no** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **37,543** Line **39**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **no**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **27,450**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **no** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **no** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **no** Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **yes**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **no** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **yes**
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **no**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **n/a** If no, please explain. **n/a**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **n/a**
Attach invoices and a summary of services for all architect and appraisal fees.